U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General

Washington, D.C. 20530

DEC 26 1990

REGISTERED MAIL
RETURN RECEIPT REQUESTED

Honorable William Donald Schaefer
Governor of Maryland
State House
Annapolis, MD 21404

Re: Findings of Investigation, Great Oaks Center

Dear Governor Schaefer:

By letter dated November 18, 1986, we notified former Governor Harry Hughes that, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 et seq., the Civil Rights Division of the United States Department of Justice was commencing an investigation into conditions at Great Oaks Center ("Great Oaks"), a mental retardation facility located in Silver Spring, Maryland. As specified by the statute, we are now writing to inform you that further review confirms that unconstitutional conditions exist at Great Oaks, and also to advise you of the minimum measures we believe may be necessary in order to remedy those conditions.

Our investigation consisted, first, of several comprehensive tours of Great Oaks by independent experts, most recently on May 15 and 16, 1990. The experts observed conditions in all the residential units of Great Oaks at various times of the day, interviewed administrators, staff and residents, and examined a variety of records. Further, we gathered and analyzed documentation relating to the operation of Great Oaks, including: a variety of policies and procedures; information relating to staffing; minutes from various committees, including the Behavioral Management Committee and the Executive Staff Committee; police reports; incident and investigation reports; mortality reviews; injury reports; restraint logs; list of residents on medications; and residents' records. We have also reviewed the Statement of Deficiencies and Plan of Correction resulting from a survey conducted by the Health Care Financing Administration in 1989 and other documents related thereto.

Based upon our extensive investigation, we believe that conditions exist at Great Oaks that are depriving residents of their constitutional rights. The United States Supreme Court has clearly stated that institutionalized mentally retarded persons have a constitutional right to adequate medical care, reasonable safety, and such training as an appropriate professional would consider reasonable to ensure their safety and freedom from undue bodily restraints. Youngberg v. Romeo, 457 U.S. 307, 324 (1982). We have concluded that the State subjects its residents of Great Oaks to conditions that violate their constitutional rights, including conditions that seriously threaten the health and safety of Great Oaks residents. These conditions include:

1. Failure to provide sufficient training to residents to avoid undue risks to their personal safety and unreasonable use of physical or chemical restraints.

2. Failure to provide sufficient numbers of appropriately trained staff to render and implement professional judgments regarding necessary care, training, and medical treatment.

3. Failure to adequately protect residents from physical injury.

4. Failure to provide adequate physical therapy services.

5. Failure to keep and maintain such records as will allow staff to render professional judgments regarding care and treatment of residents.

Set forth below are our findings and recommendations.

I. Inadequate Training Programs

Because of shortages of both psychologists and psychiatrists, Great Oaks fails to provide professionally designed and implemented training programs sufficient to ensure that residents are not subjected to unreasonable risks to their personal safety and undue bodily restraint. Our expert psychologist found that the few psychologists on duty have such excessive caseloads and professional responsibilities that they do not have adequate time to render judgments with respect to matters within their professional responsibilities, including the design and implementation of training programs.

Psychologists, additionally, have insufficient time to supervise and provide necessary training to direct care workers.

Due to the lack of training, direct care workers lack skills necessary to implement and monitor behavior training programs. Data collected by such untrained and unsupervised workers is largely unreliable. As a result of the shortage of psychologists, treatment programs are not individualized and often contain inappropriate or incompatible goals. They often remain the same from year to year. The failure to develop consistent and necessary training programs, to implement and monitor them, and to collect and record accurate and pertinent progress data places residents at substantial risk of harm to their personal safety.

Individual training programs are not implemented under the requisite supervision of a qualified professional. The programs are not prepared by the Interdisciplinary Teams with a view toward the achievement of clearly defined goals and objectives, confusing further the untrained direct care workers who are supposed to implement them but do not know what to look for or what to record. Our expert psychologist concluded that the current practice of behavior modification at Great Oaks fails to reduce self-abusive, aggressive, and other maladaptive and inappropriate behaviors. The individual training programs reviewed reflect inconsistent and inaccurate data collection, implementation and monitoring. It was quite apparent that the direct care staff did not know the elements of the residents' training programs or know how to carry them out.

The training programs were seriously deficient, resulting in residents failing to receive such training as is reasonably necessary to protect them from unreasonable risks of harm. Additionally, there is inadequate supervision of residents. As a result of these problems, rocking, pacing, and aimlessly wandering residents were seen throughout the institution. Instances of self-abuse were not an uncommon sight; observed attempts to intervene appropriately were rare. Many residents were observed to have cuts, bruises and scrapes. Clearly, many of the injuries may have been preventable with more effective programming and if more trained staff were available.

Staff resort to chemical and physical restraints to control residents' behavior, in lieu of professionally designed training programs, in violation of the residents' constitutional rights. When physical restraints are employed, they are not consistently monitored and evaluated by qualified professional staff. Although there is a formal policy defining physical restraints and outlining procedures for recording and reporting the use of such restraints, our discussions with the psychology staff revealed that the policy is not routinely followed. We found that physical restraints, i.e., helmets or arm splints, were often identified as "protective devices" when they were used to implement a resident's behavioral program, notwithstanding that the restraint policy includes no such category. When so

categorized, this restraint usage was not reported and monitored as the physical restraint policy required. As a result, many Great Oaks residents are placed in restraints without policy guidance.

Additionally, because use of restraints was often not consistent with the residents' behavioral programs, individual effectiveness was difficult to assess. In the absence of adequate behavior programming and collection of data against which the use of such restraints can be measured, the management of residents who are subjected to physical restraints does not meet professional standards of care.

One consultant psychiatrist is available only two days per month to attend to the approximately seventy residents on psychotropic medications and to other residents who might require psychiatric services. Such limited psychiatric coverage is not adequate to ensure residents' safety or to facilitate their ability to function free from chemical restraints. Because of the minimal time he spends at Great Oaks, the consulting psychiatrist must devote his time almost exclusively to medication review. The residents on psychotropics and the most difficult behavior cases receive minimal psychiatric care. Psychotropic medications are being administered in the absence of adequate training programs, including behavior modification programs. This administration of psychotropic medications departs significantly from professional practice, subjects residents to undue risks of personal harm, and results in chemical restraint of Great Oaks' residents for the convenience of staff.

In sum, Great Oaks lacks adequate and necessary training programs. The failure to provide these programs and the use of psychotropic medications in lieu of such programs represent substantial departures from accepted professional practice. Regrettably, our consultant concluded that these activities may expose residents to undue risks to their personal safety.

II. Insufficiently Trained Direct Care Staff

The safety of Great Oaks' residents is threatened by the inadequate training of direct care staff for the myriad tasks assigned to them. Additionally, Great Oaks' policy is to deploy direct care staff pursuant to fixed ratios, irrespective of the needs of the residents served. This policy further imperils the health and safety of its residents.

There is a widespread failure to appropriately manage maladaptive resident behavior. The majority of staff questioned about a specific resident's behavioral programs were unaware of the components. During our tour, we rarely observed competent staff intervention. In many cases, self-abusive or aggressive

residents were ignored by staff. Our experts concluded that direct care staff do not possess the technical competence to adequately supervise and train residents of Great Oaks.

Direct care staff training at Great Oaks is deficient and contributes to inadequate care by staff. The department responsible for staff training is understaffed. Our review indicated that the training department is also underutilized. Our experts' review of training materials indicated that the training given to the staff is insufficient in depth and scope to enable them to adequately provide essential care to residents. Because of inadequate numbers of professional psychology staff, the direct care staff receives little or no training concerning how to effectively intervene to prevent or deal with acting out behaviors of residents or to implement residents' individualized training programs.

Staff deployments are made without reference to the treatment or training needs of residents. No provision appears to be made to provide richer staffing ratios where residents have more acute problems.

As a result of inadequately trained direct care staff and improper deployment, residents fail to receive adequate daily supervision. This failure contributes to an alarmingly high frequency of resident injuries. Nearly 2,000 incidents were reported for the period between April 1, 1989, and March 31, 1990, of which approximately 50% were the result of self-injurious behavior or assaultive altercation between residents. Of the remaining injuries, about 25% were "unexplained," and another 10% were the result of "falling." 1/

In some cottages, egress is impeded due to the practice of both locking the day room door and "double locking" the outer door. As a result, staff is required to unlock three separate locks with three different keys. Apparently untrained staff had difficulty unlocking these doors under ordinary conditions of daily living. In the event of an emergency, the requirement to unlock three different locks would impede the prompt evacuation

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1/ Documents provided by Great Oaks include complaints of residents, parents, and coworkers that direct care staff has abused residents. Certain units have a disproportionately high percentage of such complaints. Although staff have been disciplined and a number of criminal charges have been lodged, many incidents of such abuse are unresolved. Complaints have been closed due to a lack of reliable witnesses. When these allegations are viewed in tandem with the large percentage of unexplained injuries, the possibility that such abuse exists is multiplied.

of residents and, as such, represents a real danger to the residents.

As a consequence of the foregoing staffing inadequacies, residents of Great Oaks are exposed to serious risks to their health and safety.

III. Inadequate Physical Therapy Services

After an exhaustive review of the physical therapy program at Great Oaks, our consultant found that many residents with physical handicaps have not been assessed and evaluated, that assessments that have been done are incomplete and otherwise inadequate, that many residents in need of physical therapy are not receiving any, and that residents listed as receiving physical therapy are receiving inadequate services.

Our consultant found that many Great Oaks residents in need of assessments, evaluations, or direct service from the physical therapy department were not receiving any whatsoever. Based upon our investigation, we have determined that Great Oaks fails to provide sufficient physical therapy staff to render appropriate care and adequate medical treatment, and to implement physical therapy programs consistent with qualified professional judgment. Physical therapy evaluations, goals, and recommended therapy programs were often inappropriate, inaccurate, or inadequate. Our review of a number of residents' records confirms that these failures have resulted in residents' physical deterioration. A number of residents have lost the ability to feed themselves, walk, or propel their wheelchairs. Such harm may be directly attributed to inadequate or inappropriate physical therapy programs and inadequate staff and staff training.

Additionally, our investigation found residents who were not "positioned" properly in wheelchairs or other devices. The lack of proper positioning is dangerous and causes harm to individual residents in that it adversely affects their ability to eat and digest food, causes new physical deformities to develop and existing deformities to worsen -- all of which adversely affects overall health. Moreover, we found residents who were positioned in a manner that actually increased their deformities and caused their conditions to worsen. Our consultant attributed the improper positioning of residents to a lack of sufficient and adequate positioning equipment and inadequacy of numbers and training of staff.

IV. Inadequate Recordkeeping

Recordkeeping at Great Oaks is deficient. Behavioral records of residents are not maintained and progress data are not collected in a consistent fashion. The consequence of the failure to maintain adequate records is that responsible staff

are unable to render professional judgments regarding care, treatment, and training of residents of Great Oaks, thereby subjecting them to unnecessary risks of harm.

Staff have not been adequately trained and do not appear to have the requisite time available to comply with the policies and recordkeeping systems at Great Oaks. Although resident records contain voluminous amounts of paperwork, the usefulness of the information is questionable. Great Oaks has not established recordkeeping systems and procedures to ensure reliability and validity of information relevant to the care and training of residents. Methods for collecting baseline data, follow-up, and progress data are absent or inadequate. There appears to be no internal evaluation or quality control procedures to determine whether policies and procedures formulated to protect residents are finally implemented by staff.

Inaccurate or incomplete behavioral data collection and recordkeeping present an active danger to residents by depriving professional and other staff of information necessary to make appropriate and safe decisions regarding training of residents. Treatment decisions are implicated as well because, in the absence of accurate behavioral data, management of patients on psychotropic medications cannot take place consistent with professional standards of practice.

Minimally Necessary Remedies

The administration and staff at Great Oaks appear committed to providing residents with appropriate care in a safe environment. Nevertheless, as discussed above, Great Oaks residents are being subjected to egregious or flagrant conditions that deprive them of their constitutional rights pursuant to a pattern or practice of resistance to the full enjoyment of these rights. To rectify the deficiencies at Great Oaks and to ensure that constitutionally adequate conditions are maintained thereafter, we propose to enter into an agreement with the State of Maryland which shall be entered as an order of a Federal Court and which shall provide, at a minimum, that Great Oaks shall implement the following remedies:

1) The State must provide professionally designed training programs to the residents at Great Oaks who need them and for whom training will reduce or eliminate unreasonable risks to their personal safety and/or the need to use undue bodily and chemical restraints, and must ensure that such programs are appropriately implemented by trained staff. Immediate attention must be given to residents with self-injurious, physically abusive and other destructive behaviors by identifying them and providing necessary training on a priority basis.

2) The State must provide professionally designed physical therapy programs for the residents at Great Oaks who need them, and ensure that such programs are appropriately implemented by trained staff. Immediate attention must be given to ensure that residents are provided care sufficient to, at least, prevent deterioration of their physical condition.

3) The State must hire, deploy, and provide ongoing training to a sufficient number of competent and qualified direct care and professional staff at Great Oaks to provide residents there with adequate care, psychiatric treatment, physical therapy, and training programs to protect them from unreasonable risks of bodily harm and to their personal safety.

4) The State must assure that Great Oaks develops and implements recordkeeping systems to monitor the use and effectiveness of behavior and other programs and training, and the use of medications, and allow re-evaluations as appropriate.

Information about Federal financial assistance which may be available to assist with the remedial process can be obtained through the United States Department of Health and Human Services' Regional Office (Director, Intergovernmental and Congressional Affairs), and through the United States Department of Education by contacting the individuals listed in the enclosed information guide.

Our attorneys will be contacting the Maryland Attorney General's Office shortly to arrange a meeting to discuss this matter in greater detail. In the meantime, should you or your staff have any questions regarding this matter, please feel free to call Arthur E. Peabody, Jr., Chief, Special Litigation Section, at (202) 514-6255. To date, we have been able to conduct this investigation in the spirit of cooperation intended by the Civil Rights of Institutionalized Persons Act, and look forward to continuing to work in the same manner with State officials in that spirit toward an amicable resolution of this matter.

Sincerely,

John R. Dunne
Assistant Attorney General
Civil Rights Division

Enclosure

cc: Honorable J. Joseph Curran, Jr.
Attorney General
State of Maryland

Breckinridge L. Willcox, Esq.
United States Attorney

Ms. Lois M. Meszaros
Director
Maryland Mental Retardation and
Developmental Disabilities Adminsitration

Marvin M. Malcotti, Ph.D.
Director
Great Oaks Center

Michael J. Astrue, Esq.
General Counsel
United States Department of Health
and Human Services

Gail R. Wilensky, Ph.D.
Administrator
Health Care Financing
Administration